

**STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
INCOME CONTINUATION INSURANCE FORMS/BOOKLETS ORDER FORM**

Employer Name: _____ **EIN: 69-036-**_____

Street Address: _____

Mailing Address: (if different) _____

Contact Name: _____

Contact Phone: _____

State & Local Employer Orders

Please indicate forms and quantity needed:

<u>Forms/Booklets</u>	<u>Quantity</u>
<input type="checkbox"/> ET-2106 ICI Booklet – State (rev 02/2000)	_____
<input type="checkbox"/> ET-2129 ICI Booklet – Local (rev 02/2000)	_____
<input type="checkbox"/> ET-2307 ICI Enrollment Form (rev 10/99)	_____
<input type="checkbox"/> ET-2308 ICI Evidence of Insurability (EOI) Enrollment (rev 6/97)	_____
<input type="checkbox"/> ET-5106 Claim Filing Instructions for the Income Continuation Insurance and Long Term Disability Insurance Plan (8/01)	_____
<input type="checkbox"/> ET-5901 ICI Transaction Report (rev 12/2000)	_____
<input type="checkbox"/> State Claim Packet (ET-2106, ET-5350 and ET-5352)	_____
<input type="checkbox"/> Local Claim Packet (ET-2129, ET-5350 and ET-5352)	_____
<input type="checkbox"/> ET-1119 State Employers ICI Administration Manual (rev 9/88)	_____
<input type="checkbox"/> ET-1145 Local Employers ICI Administration Manual (rev 9/97)	_____

Return to: CORE Correspondence Unit	Fax: (310) 348-7126
P.O. Box 451639	Email: ICILTDI@COREINC.com
Los Angeles CA 90045	

Date Received at CORE: _____ **Date Processed:** _____